WORKGROUP PLAN TO ACHIEVE FUNDING EQUITY FOR ALL CMHSPS

(FY2007 Appropriation Bill - Public Act 330 of 2006)

May 31, 2007

Section 462: The department shall establish a workgroup comprised of representatives of the department, CMHSPs, legislature, and any other persons considered appropriate to develop a plan to achieve funding equity for all CMHSPs that receive funds appropriated under the community mental health non-Medicaid services line. The funding equity plan shall establish, at a minimum, a payment schedule or scale to ensure that each CMHSP is paid or reimbursed equally based on the recipient's diagnosis or individual plan of service sufficient to meet his or her needs, or both. The department shall submit the written plan to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2007.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

STATE OF MICHIGAN

JENNIFER GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

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June 1, 2007

A REPORT TO COMPLY WITH THE REQUIREMENTS OF SECTION 462 OF PUBLIC ACT 330 RECIPIENT LEVEL FUNDING EQUITY FOR COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

BACKGROUND

The FY 07 appropriations bill (Act 330 of the Public Acts of 2006) for the Michigan Department of Community Health (MDCH) specifies that:

> "The department shall establish a workgroup comprised of representatives of the department, CMHSPs, legislature, and any other persons considered appropriate to develop a plan to achieve funding equity for all CMHSPs that receive funding appropriated under the community mental health non-Medicaid services line. The funding equity plan shall establish, at a minimum, a payment schedule or scale to ensure that each CMHSP is paid or reimbursed equally based on the recipient's diagnosis or individual plan of service sufficient to meet his or her needs, or both. The department shall submit the written plan to the house of representatives and senate appropriations sub-committees on community health, the senate and house fiscal agencies, and the state budget director by May 31, 2007."
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> - Section 462 of P.A. 330

Similar language was included in the department's appropriation bill for FY 06 (PA 154 of the Public Acts of 2005). MDCH established (in 2006) a workgroup consistent with boilerplate stipulations and issued the required written report on the activity and conclusions of this endeavor.[1]

The FY 06 report outlined statutory and practical difficulties to achieving "recipient equity" in the distribution of general funds to community mental health services. Under the Code, the department is directed to "…promote and maintain an adequate and appropriate system of community mental health services programs throughout the state"[2], and to consider both statewide and local needs in making an allocation of state appropriated funds to a CMHSP.[3] Funds allocated to the CMHSP are intended to support "…a comprehensive array of mental health services appropriate to the condition of individuals located within its geographic area"[4], with the expectation that priority for service provision will be afforded to those with the most

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[1] *A Report to Comply with the Requirements of Section 462 of Public Act 154*, June 1, 2006
[2] MCL 330.1116(2)(b)
[3] MCL 330.1234
[4] MCL 330.1206

severe forms of serious mental illness, serious emotional disturbance or developmental disability.[5]

The language of the Code reflects a particular (historical) orientation and conceptual framework regarding system organization, target populations for care, service delivery arrangements, and funding allocations. This orientation and framework is often referred to as the "community-model" of public mental health services. Under this approach, community mental health services programs (CMHSPs) are responsible for: a) estimating overall community need and the likely demand for mental health services (needs assessment), with a special focus on calculating the size of certain target groups (i.e., priority populations); b) identifying the scope, availability, capacity and sufficiency of existing services (supply) in relation to anticipated need/demand; c) projecting the type and amount of additional services or programs required to adequately meet the "comprehensive mental health needs" of the population and, particularly, the target (priority) groups; d) integrating this information into an annual program plan, proposed budget, and request for funding; and e) submitting the plan/proposed budget/funding request to the department for review. As noted above, the department is responsible for examining the CMHSP annual program plan, and for making allocation decisions (subject to the constraint of funds actually appropriated by the legislature) according to the considerations (i.e., state needs, local needs, etc.) outlined in MCL 330.1234.

The conceptual framework and legal underpinnings for general fund distribution emphasizes estimation of community and special population needs, assessment of the types, scope and adequacy of existing services, and allocation of funds within the constraints of funds appropriated by the legislature for this purpose. In short, the Code implies a "community-centered structure" for general fund allocations (assessment of population and special needs and available service capacity) and an underlying principle of equitable treatment of county-sponsored CMHSPs, rather than "recipient-equalized" or individual "severity-adjusted" general fund allocation. The FY 06 report described the upshot of these considerations, concluding that:

> "…no funding equity plan for state general funds could be legally structured '…to ensure that each CMHSP is paid or reimbursed equally based upon a recipient's diagnosis or individual plan of service sufficient to meet his or her needs.' Modifying CMHSP general fund allocations to reflect individual recipient diagnosis, characteristics or severity-related needs imply an individual entitlement and a defined benefit program (an insurance like arrangement), rather than the priority designations, defined contribution, and permissible service constraints described in Chapter 2 of the Mental Health Code."[6]

FUNDING EQUITY EFFORTS OVER TIME

The report issued in 2006 contained a brief review of past attempts to achieve greater "equity" in general fund allocations. The history, features, objectives, components, incentives, distortions, and adjustments related to these previous efforts have been fully chronicled elsewhere[7] and won't be repeated here. It should be noted, however, that earlier "models" for general fund distribution relied heavily on the annual needs assessment process (utilizing various "accepted" estimation methodologies, including epidemiological data, social indicators, key informant information, existing service statistics, etc.) and the identification of gaps in the type, scope and or capacity of existing community services and programs.

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[5] MCL 330.1208
[6] *A Report to Comply with the Requirements of Section 462 of Public Act 154*, June 1, 2006, page 3.
[7] See: *Funding Community Mental Health in Michigan* (available at: http://www.crcmich.org/PUBLICAT/1990s/1997/rpt318.pdf); and *History of Community Mental Health Financing* (http://www.michigan.gov/mentalhealth/0,1607,7-201-28855-94038--,00.html)

While there has always been keen interest regarding the rationale behind the department's general fund allocation decisions, the clamor for an explicit "formula" for distribution is a relatively recent phenomenon (circa 1995-1997). With the adoption of "full management" status by all CMHSPs, the closure of 13 state facilities in seven years, the 1996 Code amendment allowing CMHSPs to "carry forward" up to 5% of their general fund allocation each year, the "cap" on local (county) match requirements for CMHSPs that became mental health authorities (i.e., the cap essentially lowered the "price" of obtaining additional state funds, since the county did not have to contribute the usual 10% match for any additional state funds acquired) and the change in state policy from Medicaid maximization to Medicaid cost containment (illustrated by the abrupt move to managed care), interest shifted from the past model of needs assessment and departmental discretionary allocation decisions based on need and capacity, to some form of a mathematical/statistical formula for general fund distribution.

The first mathematical "formula" for general fund distribution was developed in 1997 by the Citizen Research Council (CRC) of Michigan. This new distribution formula used three factors (weighted differently in the calculations) that purportedly reflected "need": a) the number of Medicaid recipients (25% weight) in the CMHSP catchment area; b) the number of uninsured (25% weight) in the catchment area; and c) a synthetic estimate of the prevalence of serious mental disorders (50% weight) in the catchment area. Computations were then made using these formula "input" values (and their respective weights) to determine the "share" of general fund that should be distributed to each CMHSP. Since these calculations produced significant changes in allocations from the existing distribution, "limits" were used to constrain the extent of redistribution from that which would have occurred if allocations were determined solely by the new formula.

There were a number of critiques of the 1997 formula, including questions about the components selected as measures of need, the weights assigned to these variables in the allocation formula, the lack of attention to geographic costs differences in the provision of service, and failure to consider the availability or differential distribution of other funding from local, state and federal sources (e.g., Medicaid; earned contracts, etc.) which affect the total "fiscal capacity" of a CMHSP to support service provision.

In 1999, the formula for general fund allocation was changed to one that used: a) population (10%); b) poverty under age 18 (15%); c) poverty over 18 (35%); and d) estimates of the prevalence of serious mental disorders (40%). However, over the past 7 years, changes in general fund allocations have typically **not** been "equity-oriented" or formula-driven, but rather reflected executive order (2002) reductions, the need to move funds to support (as part of the non-federal share) Medicaid capitation levels, a redirection of funds to finance elements of the Adult Benefit Waiver, and allocation adjustments to compensate for Medicaid funding swings and to assure some measure of financial stability for affected organizations.

FUNDING EQUITY EFFORTS IN FY 07

There has been limited departmental-sponsored activity on funding equity in FY 07. The few meetings of the funding equity workgroup convened by the department subsequent to the FY 06 report revealed the many challenges to establishing greater "equity." There are differences (among stakeholders) regarding what is meant by the concept of equity (e.g., recipient equity, taxpayer equity, organizational fiscal-capacity equity, etc.), complexities in determining and weighting variables of need, disagreements on how to measure and incorporate differences in cost of services (COS) as a formula component, data source and data quality issues, and

questions regarding whether improving "equity" in one funding strand (general fund) might potentially *increase* overall fiscal disparities (total organizational fiscal-capacity) within the current, very complex and intricate, multiple source funding environment. Of particular interest are differences in Adult Benefit Waiver (ABW) payments and expenditure patterns. Unlike general fund allocations (for which a CMHSP can carry forward a maximum of 5% of their authorization), 100% of the savings (unexpended funds) from Adult Benefit Waiver payments to CMHSPs can be retained, and becomes part of the CMHSP local fund balance. Some CMHSPs spend as little as 32% of ABW payments, retaining 68% of the aggregate payments. A number of CMHSPs have had significant retained "earnings" from the ABW program, and a few show very significant increases in their unrestricted fund balances.

Although the department has convened a limited number of workgroup meetings, examination of equity considerations and formulas has continued at the Michigan Association of Community Mental Health Boards (MACMHB). The "Equity-Proxy Committee" of MACMHB funded a preliminary study of "proxy" indicators for a "mental health need index"[8], a possible new component in a revised formula for allocation of general funds. The committee also examined various methods for incorporating geographic "cost of service" differences within a revised formula. However, it is our understanding that MACMHB has not yet achieved consensus within its membership regarding a preferred distribution method or formula.

The department believes that every source of funding, all forms of carry-forward and "retained" ABW funds, earned contract revenues, and the size of an organization's unrestricted fund balance, must be considered in determining the overall fiscal capabilities of the organization. From that perspective, while some level or "floor" of general fund dollars should be allotted to each CMHSP, we believe that the residual portion of available general funds must be distributed under the standard of "expenditure need",[9] or equalization of the fiscal capabilities among CMHSPs. The concepts of "expenditure need" and organizational fiscal capacity suggest that the various mixtures of Medicaid capitation, ABW payments, base GF allocations, earned contract revenue, carry-forward dollars, retained ABW savings, and unrestricted fund balance levels may generate significant inequities in overall fiscal capacity between different entities. To mitigate such disparities, some general funds should be reserved and allocated to organizations to reduce the "expenditure need", the gap between what other entities have through an assortment of funding arrangements and retained earning, and what the more disadvantaged organization needs to sustain and provide a certain standard level of service provision. This approach, we believe, is consistent with our legal responsibility to "…promote and maintain an adequate and appropriate system of community mental health services programs throughout the state."

[8] See*: Preliminary Data Options for the Development of a Mental Health Need Index for the State of Michigan*, prepared by Dr. Christopher G. Hudson for the Equity-Proxy Committee of the Michigan Association of Community Mental Health Boards (September 2006)

[9] For an elaboration of some of these concepts and approaches see: *Review and Evaluation of the Substance Abuse and Mental Health Services Block Grant Allotment Formula,* RAND Corporation (1997); and also the monograph *Statistical Issues in Allocation Funds by Formula,* from the National Research Council (2003)